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CLIENT ADVISORY
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CMS Releases 2016 OPPS Proposed Rule with Modifications to the Two-Midnight Rule

On July 8, 2015, the Centers for Medicare and Medicaid Services ("CMS") will publish the calendar year 2016 proposed rule for the Hospital Outpatient Prospective Payment System ("OPPS") and the Ambulatory Surgical Center ("ASC") payment system. In addition to recommending OPPS and ASC payment rate adjustments, the proposed rule revises requirements for hospitals billing for chronic condition management ("CCM") services and provides guidance on future enforcement of the two-midnight rule governing short inpatient hospital stays.

I. Modifications to the Two-Midnight Rule

CMS' two-midnight rule was enacted as part of the 2014 Inpatient Prospective Payment System ("IPPS") final rule and revised Medicare's definition of an inpatient for payment under Part A. Under the two-midnight rule, an inpatient is a patient who is admitted to the hospital with the expectation that the patient will need hospital care crossing two midnights. In a later guidance document, CMS acknowledged that there may be "rare and unusual" circumstances in which an inpatient admission may be appropriate even if the physician did not expect the patient's stay to cross two midnights.

In light of continued stakeholder concerns related to implementing the two-midnight rule, CMS is now proposing to modify its existing "rare and unusual" exceptions to allow for Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark. To qualify for this exception, documentation in the medical record must support the admitting physician's determination that the patient requires inpatient hospital care, despite an expected length of stay that is less than two midnights.

CMS has proposed three factors relevant to determining whether an inpatient admission, where the patient stay is expected to be less than two midnights, is nonetheless appropriate for Part A payment:

- Severity of signs and symptoms exhibited by the patient;
- Medical predictability of something adverse happening to the patient; and
- Need for diagnostic studies that appropriately are outpatient services (performance does not ordinarily require the patient to remain at the hospital for 24 hours or more).

Under the revised policy, an inpatient admission will be payable under Part A if the documentation in the medical record supports either the admitting physician's reasonable expectation that the patient will require hospital care spanning at least two midnights, or the physician's determination, based on the above factors, that the patient requires formal hospital inpatient admission for a period lasting less than two midnights. In all cases, the physician's decision to admit the patient must be reasonable, necessary, and supported by clear documentation in the medical record. The care furnished must also be reasonable and necessary.

CMS is modifying its medical review strategy in response to industry pushback regarding recovery audit contractor ("RAC") activity and the subsequent backlog of appeals. Since the two-midnight rule was established, CMS has delayed enforcement by RACs. Instead, Medicare Administrative Contractors ("MACs") have conducted "probe and educate" reviews for compliance with the two-midnight rule. Effective no later than October 1, 2015, CMS will transition the medical review of short inpatient stays from the MACs to the Quality Improvement Organization ("QIO") contractors. Hospitals exhibiting a pattern of high denial rates, consistent failure to adhere to the two-midnight rule, or failure to improve their performance after QIO intervention will be referred to the RACs for further audit.

RACs will be permitted to resume reviews for dates of admission after September 30, 2015. After that date, RACs will begin to conduct patient status reviews focused on providers that are referred from the QIOs. The number of

claims subject to RAC review will be based on the claim volume of the hospital and the denial rate identified by the QIO. CMS will adopt this new medical review strategy regardless of other changes to the two-midnight rule in the final rule.

II. OPPS and ASC Payment Updates

CMS has proposed a net conversion factor reduction of 0.3% for 2016 OPPS payments for providers meeting the Hospital Outpatient Quality Reporting ("OQR") Program reporting requirements. Those hospitals failing to meet the OQR Program requirements would be subject to a two-percentage-point payment reduction. Total OPPS payments for 2016 are expected to decrease by approximately $43 million compared to 2015.

CMS proposes to increase 2016 payment rates under the ASC payment system by 1.1 percent for providers meeting the quality reporting requirements of the ASC Quality Reporting ("ASCQR") Program. ASCs failing to meet the ASCQR Program requirements would incur a two percentage point payment reduction. The proposed total payments to ASCs would increase by approximately $186 million compared to 2015.

III. Proposed CCM Requirements for Hospitals

For 2016 and subsequent years, CMS is proposing additional requirements for hospitals billing and receiving OPPS payments for CCM services under CPT code 99490. CMS has never specified whether the hospital furnishing the clinical staff portion of CCM services must have an established relationship with the patient. For 2016 and beyond, CMS proposes that hospitals only be permitted to bill for CPT 99490 when furnished to a patient who has either been: (1) admitted to the hospital as an inpatient; or (2) a registered outpatient of the hospital within the last 12 months and for whom the hospital furnished therapeutic services. Though most hospitals likely already meet this requirement, CMS proposes to make this an explicit condition of payment for CCM services under the OPPS.

CMS proposes to adopt beneficiary notice requirements for hospitals billing for CCM services that are analogous to those in the 2015 Medicare Physician Fee Schedule ("PFS") final rule. Under the proposed rule, hospitals would be required to: (1) document in the medical record whether a beneficiary accepts or declines CCM services after they were explained and offered; (2) inform beneficiaries that they could incur two separate copayments from both the hospital and the physician; and (3) notify beneficiaries that only one hospital can furnish and be paid for CCM services during the calendar month service period.

In addition, CMS proposes analogous scope of service elements for hospital CCM services. These elements include, among others, the creation and dissemination of a patient-centered care plan using certified electronic health record ("EHR") technology and enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner through means of secure messaging, Internet, or other non-face-to-face methods.

Stakeholder comments must be submitted by 5:00pm on August 1, 2015. If you have any questions about CMS's 2016 OPPS/ASC proposed rule or how these policy changes may affect your organization, please contact Mary Malone, Colin McCarthy, or Corbin Santo at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C., is available on the firm's website at www.hdjn.com.

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